GEORGIA SKIN CANCER
& Aesthetic Dermatology

1180 Resurgence Drive
Suite 100
Watkinsville, GA 30677

Obtaining from:
Please **mail** records
larger than 20 page.

MEDICAL RECORDS REQUEST/RELEASE FORM

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE GEORGIA SKIN CANCER TO: *INITIAL BELOW*

_____ **RELEASE INFORMATION TO:**	_____ **OBTAIN INFORMATION FROM:**

_____

Person or Entity or Name of Provider or Facility

_____

Address/City/State/Zip

_____

Phone Number Fax Number

Please *initial* specific information requested for release:

_____ Biopsy Results and Lab Reports – Specify, if needed: _____

_____ Dermatological Surgical Procedures – Specify, if billing related: _____

_____ Medications/Prescription Plans

_____ Progress/Office Notes – Specify, if applicable: _____

_____ All Protection Health Information (PHI) in medical record

_____ Other: _____

For the purpose of: CHECK ONE

___ Healthcare Facility/Continuing Care
___ Insurance/ Cancer Policy
___ Legal
___ Transferring Care
___ Personal
___ Physician
___ Disability
___ Other (please specify): _____

I understand I may revoke this authorization at any time in writing and present my written revocation to the Georgia Skin Cancer facility. Unless otherwise revoked, this authorization will expire one year from the date below signed or as listed: _____ / _____ / _____.

_____ _____
Patient Name (Print) Date

_____ INTERNAL USE: MRN _____
Patient Signature Requested By: PROVIDER _____ / PATIENT